Influenza Vaccine

VACCINE ADMINISTRATION RECORD

I. Please <u>PRINT</u> the following information about the person to receive the vaccine.

NAME _____
(First) **(***Middle Initial)* **(***Last)*

STREET_____**CITY**_____**COUNTY**_____**STATE** _____**ZIP**_____

PHONE # _____ **SOCIAL SECURITY #**_____**BIRTHDATE**_____

SEX **M** **F** **MARITAL STATUS** **Single** **Separated** **Married** **Divorced** **Widowed** **Unknown** **STUDENT?** **YES** **NO** **Where?** _____

The following information is for statistical purposes:

RACE **American Indian/Alaskan Native** **Black/African American** **White** **Asian** **Native Hawaiian/Other** **Unknown**
(CIRCLE ONE)

HISPANIC ORIGIN ***Non-Hispanic*** ***Hispanic Cuban*** ***Hispanic Mexican*** ***Hispanic Other/Unknown*** ***Hispanic Puerto Rican*** ***Hispanic South American***
(CIRCLE ONE)

III. CONSENT I have read or have had explained to me the information in this consent and the information sheet about **influenza** and **influenza vaccine**. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of **influenza vaccine** and ask that the vaccine be given to me or to the person named on this form for whom I am authorized to make this request.
I consent to inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the person named above.

I request that payment of authorized Medicare, Medicaid (including First Guard/Health Wave/Health Connect) and/or BCBS benefits be made on my behalf to the Riley County-Manhattan Health Department for any services furnished me by that facility. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand I will be responsible for payment of charges for services deemed "uncovered" by medicaid and/or my health insurance. This constitutes advance notice to myself, the beneficiary, that if all program requirements are met by the Riley County-Manhattan Health Department and payment is not made by KMAP, I may be held responsible for the charges, if my services are not covered by KMAP. I may also be responsible for charges if I fail to inform the Health Department of Medicaid/Healthwave coverage in a timely manner.

X_____ **Date:**_____
Signature of Client or Parent/Guardian

For Clinic/Office Use Only

Clinic/Office Address: RILEY COUNTY-MANHATTAN HEALTH DEPARTMENT

Date Vaccine Administered: _____ **Site of Injection**_____

Signature & Title of Vaccine Administrator _____

Vaccine Manufacturer, Lot #, and Expiration Date:

(LABEL)

PT# _____

ENC#_____

PAYOR _____